84-1309

Office Supreme Court, U.S.
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No.....

In The
Supreme Court of the United States
October Term, 1984

EULA B. STARNES, *et al.*,

Petitioners,

v.

MARGARET M. HECKLER, Secretary of Health and Human Services, *et al.*,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the district court has subject matter jurisdiction under 28 U.S.C. § 1331 or 28 U.S.C. § 1361 to enjoin the Secretary's further implementation of arbitrary caps on Medicare Part B reimbursement for covered medical services until the Secretary complies with the notice and comment requirements of the rulemaking provisions of the Administrative Procedure Act ("APA") (5 U.S.C. § 553)?

2. Whether the district court has jurisdiction under 28 U.S.C. § 1331 or 28 U.S.C. § 1361 to review petitioners' constitutional and statutory challenges to the Secretary's unlawful conduct in the administration of the Medicare Part B program?

PARTIES TO THE PROCEEDING

The named petitioners are (1) Eula B. Starnes, Johnnie Kay Lloyd, Nettie E. Clarkson, Jayne E. Dunlap, and Mae T. Sanders, who are individuals enrolled in Part B of the Medicare program; (2) Julian Adams, Fred H. Allen, Jr., William H. Stuart, and O. Rhett Talbert, who are physicians specializing in neurology; and (3) Trident Neuro-Imaging Laboratory (a South Carolina general partnership in which petitioner Talbert is a partner), CT Scanlab (a North Carolina limited partnership in which petitioner Allen is a partner), and Atlanta Neurological Clinic, P.C. (a Georgia professional corporation in which petitioner Stuart is a principal), each of which owns and operates CT scanner equipment used in furnishing services to Medicare Part B and non-Medicare patients. Petitioners Starnes, Lloyd, Clarkson, Dunlap, and Sanders represent a class of all Medicare Part B beneficiaries who have sought or seek Medicare benefits for CT head scan services. The other named petitioners represent a class of all physicians and physician-directed clinics that own, operate, and use CT scanners in providing CT head scan services to Medicare Part B beneficiaries.

In addition to the Secretary of Health and Human Services, Blue Cross and Blue Shield of South Carolina, Inc. and Prudential Insurance Company of America, are named respondents. Blue Shield and Prudential have contracted with the Secretary as "carriers" to administer the Medicare Part B program in South Carolina, North Carolina, and Georgia. Counsel for the Secretary also represents these carriers.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

Eula B. Starnes and other petitioners who participate in the Medicare Part B program as enrolled beneficiaries or as suppliers of covered CT head scan services petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit rendered on remand of the case from this Court for further consideration in light of *Heckler v. Ringer*, 466 U.S. —, 104 S. Ct. 2,013 (1984).

OPINIONS BELOW

The per curiam opinion of the court of appeals on remand (App. A, *infra*, App. 1-3) reversing the district court's exercise of jurisdiction is reported at 748 F.2d 217. The June 4, 1984 order of this Court (App. C, *infra*, App. 6) granting the Secretary's petition for a writ of certiorari, vacating the initial judgment of the court of appeals, and remanding the case for further consideration in light of *Ringer* is reported at — U.S. —, 104 S. Ct. 2,673. The 1983 initial opinion of the court of appeals (App. D, *infra*, App. 7-24) affirming the district court's exercise of jurisdiction is reported at 715 F.2d 134. The March 6, 1980 order of the district court (App. E, *infra*, App. 25-33) entering a preliminary injunction against respondents for violation of APA rulemaking requirements; the October 19, 1981 order of the district court (App. F, *infra*, App. 34-36) certifying certain plaintiff classes; and the April 16, 1982 order of the district court (App. G, *infra*, App. 37-45) denying the Secretary's motion to dismiss for lack of jurisdiction and certifying the jurisdictional issue for interlocutory appeal to the court of appeals are not reported.

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JURISDICTION

The judgment of the court of appeals on remand was entered on November 13, 1984 (App. B, *infra*, App. 4). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

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STATUTORY PROVISIONS INVOLVED

28 U.S.C. § 1331 and 28 U.S.C. § 1361 and relevant provisions of the APA and the Social Security Act are reproduced at App. H, *infra*, App. 46-49.

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STATEMENT OF THE CASE

This case involves the jurisdiction of a federal district court after all administrative remedies have been exhausted to ensure that the Secretary abides by the notice and comment mandates of the APA and engages in lawful conduct in the administration of the Medicare Part B program in compliance with statutory and constitutional requirements.

Acting in disregard of the procedural safeguards embodied in the rulemaking requirements of the APA, the Medicare program during 1977-78 imposed arbitrary caps on reimbursement under Medicare Part B for covered CT head scanning services without subjecting such actions to the rulemaking process. The Medicare program's actions effectively eliminated the provision of CT head scan services in physicians' offices, forcing Medicare beneficiaries to obtain such services, if at all, in various hospitals which were not subject to the caps and where the services were far more costly and often inaccessible.

In *Schweiker v. McClure*, 456 U.S. 188 (1982), this Court observed that Congress intended for private insurance carriers to play a central role in administering Medicare Part B and in providing beneficiaries with fair hearings on benefit controversies through carrier-appointed hearing officers. These statutory functions of

Part B carriers were usurped with respect to CT scanning services through the administrative actions in question.

Petitioners seek the aid of the judicial system only to ensure that Medicare Part B is administered according to lawfully promulgated regulations. Petitioners do not seek monetary relief and have not challenged the reasonableness of the amount of benefits paid for CT head scans. The applicable decisions of this Court and a substantial body of case law developed in the courts of appeals provide overwhelming support for the district court's exercise of jurisdiction in this case and are in direct conflict with the Fourth Circuit's decision on remand.

1. *APA rulemaking requirements.* Congress has established in the APA a formal process for the publication by federal agencies of proposed rules in the *Federal Register* and for an opportunity for the public to participate in the rulemaking process through the submission of written comments. 5 U.S.C. § 553. The notice and comment requirements of the APA "were designed to assure fairness and mature consideration of rules of general application." *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 764 (1969). The rulemaking proceeding is intended to provide "procedural" protection. *Heckler v. Campbell*, 461 U.S. 458, 470 (1983).

2. *Medicare Part B.* The Medicare program, a health insurance program for the aged and disabled, consists of two basic components, Parts A (42 U.S.C. §§ 1395c *et seq.*) and B (42 U.S.C. §§1395j *et seq.*). Generally, Part A provides insurance for health services delivered by hospitals and other specified institutional providers. Part B,

which is involved in this case, provides insurance for covered medical services of physicians and other specified suppliers.

Under Part B, Medicare beneficiaries generally are entitled to 80% of the "reasonable charge" for covered medical services, including physician services. 42 U.S.C. § 1395k. In order to provide for the administration of Part B benefits with maximum efficiency and convenience for Medicare beneficiaries, the Secretary is authorized to enter into contracts with private organizations known as "carriers." 42 U.S.C. § 1395u. Such contracts must require the carriers to make reasonable charge determinations for Part B benefits and to handle the receipt, disbursement, and accounting for funds used in making payments to Part B beneficiaries or their assignees. 42 U.S.C. §§ 1395u(a)(1)(A), 1395u(a)(1)(B). Carriers are authorized to pay Part B benefits either to the Medicare beneficiary or to the physician who provided medical services on the basis of an "assignment," pursuant to which the physician agrees that the "reasonable charge" is the full charge to the beneficiary for the service. 42 U.S.C. § 1395u(b)(3)(B).

In making "reasonable charge" determinations, carriers are required by statute to apply two statutory limitations: (a) "customary" charges for similar services generally made by the physician who furnishes the services; and (b) the "prevailing" charges in the locality for similar services. 42 U.S.C. § 1395u(b)(3). Customary and prevailing charge screens are established by the carriers for this purpose. If a physician's actual charge for a service does not exceed the customary and prevailing charge limitations, the actual charge is generally the

"reasonable charge" and the basis for payment of benefits.[1]

By regulation, the Secretary has acknowledged the statutory mandate that carriers, rather than government officials, are to "exercise judgment" on a case-by-case basis in making reasonable charge determinations. 42 C.F.R. §§ 405.502(c), 405.502(d). These determinations are to be made in accordance with "broad principles" issued by the Health Care Financing Administration ("HCFA"), the component of the Department of Health and Human Services ("HHS") responsible for the Medicare program. 42 C.F.R. § 405.502(d). The regulations state that "[t]he *principles* in §§ 405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions." 42 C.F.R. § 405.502(d) (emphasis added). Thus, the regulations limit the principles by which carriers are guided in exercising their discretion to those published at §§ 405.503-405.507, and those sections of the regulations relate solely to the "customary" and "prevailing" charge criteria prescribed by statute for reasonable charge determinations. There is no authority in the statute or regulations for carriers to be guided by caps or any other guidelines in making "reasonable charge" determinations that are not lawfully promulgated in the regulations.

The statute requires that beneficiaries be afforded a "fair" hearing when an amount of $100 or more is in controversy. 42 U.S.C. § 1395u(b)(3)(C). The carrier

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[1]The statute also imposes an "economic index" limitation on annual increases in the prevailing charge limitation for physician services. 42 U.S.C. § 1395u(b)(3). The CT head scan caps were not based on the economic index limitation.

review and hearing process prescribed by statute is restricted to beneficiary (or assignee) dissatisfaction with the carrier's initial determination as to the allowable amount of benefits. *Id.;* 42 C.F.R. §§ 405.801(a), 405.807. Further, the Secretary has bound carrier-appointed hearing officiers to comply with "policy statements, instructions and other guides" issues by HCFA in conducting Part B hearings. 42 C.F.R. § 405.860.

There is no statutory review process culminating in judicial review of any Part B controversies. In contrast, Part A prescribes two separate procedures by which various reimbursement controversies are ultimately subjected to judicial review. Medicare Part A claimants are authorized to seek judicial review of a determination that a service is not "reasonable and necessary" in the same manner as is provided in 42 U.S.C. § 405(g) for old-age and disability claims arising under Title II of the Social Security Act, after their claims have been reviewed by an Administrative Law Judge and the Appeals Council. *See Heckler v. Ringer,* 466 U.S. —, —, 104 S.Ct. 2,013, 2,015 (1984). Also, Part A providers are entitled to pursue controversies with fiscal intermediaries as to the proper amount of reimbursement for covered services, when an amount of $10,000 or more is in dispute, through an appeal to the Provider Reimbursement Review Board, whose decision is then subject to judicial review. 42 U.S.C. § 1395oo.

3. *Background of the CT dispute.* Computerized tomography ("CT") scanning, also known as computerized axial tomography ("CAT") scanning, is a highly effective diagnostic tool for a variety of cranial disorders (*e.g.,* tumors, atrophy, hemorrhage, skull fractures) the

use of which enables the elimination of other time-consuming, painful, less effective, riskier, and more costly diagnostic procedures. The developers of CT scanning were awarded the 1979 Nobel Prize in Physiology or Medicine. (C.A. App. 207, 213-14).

CT head scanning became a covered service under Medicare Part B in 1976. Initially, carriers based reasonable charge determinations for CT head scans on the actual charges of physicians, subject to the customary and prevailing charge criteria that were then, and still are, prescribed in the statute and the Secretary's regulations. (C.A. App. 8).

In July 1977, the Region Office (Atlanta) of the Medicare Bureau (the predecessor to HCFA) first established caps on Part B reimbursement for CT head scans at $150 through letters issued to all carriers in Region IV. (C.A. App. 8, 27-28). A $150 nationwide cap was then established by the Medicare Bureau in December 1977, by memorandum issued to Regional Medicare Directors. (C.A. App. 8-9, 29-30). The Medicare Bureau slightly adjusted the nationwide caps in September 1978, through the issuance of Intermediary Letter 78-38 to Part B carriers. (C.A. App. 9, 31-36). The Intermediary Letter adjusted the caps to $157.50 or $172.50, depending upon the use of contrast enhancement. These caps have never been subjected to formal rulemaking.

Upon establishment of the caps, carriers throughout the United States questioned their legality, challenged them as being inequitable and unreasonable, and requested approval of exceptions, but to no avail. (C.A. App. 78-81, 87-94, 96-102). The president of one of the carrier respondents in this action testified that "[a]s a result of these

ceilings, the duties of this defendant are purely ministerial and this defendant is not permitted to exercise any discretion in connection with them." (C.A. App. 144).

Named petitioners and members of the petitioner classes challenged the caps through the carrier review and hearing process prescribed by statute and regulations. In each case, the carriers and hearing officers concluded that they had no discretion to ignore the caps. When they considered doing so, they received direct instructions from HCFA to apply the caps without deviation. (C.A. App. 122-28, 152-53, 164-91, 202-14).

In addition to pursuing individual appeals to carrier-appointed hearing officers, petitioners, individually and through representative national organizations, sought administrative relief from the caps through direct discussions with HCFA Region IV and the Secretary during the period 1977-79, but to no avail. (C.A. App. 204-05).

During the same period, in August 1978, the chief counsel for HCFA advised the HCFA Administrator that, in order to establish the caps lawfully, HCFA "will have to (1) proceed by rule-making rather than by intermediary letter and (2) make a case in the rulemaking record for why the caps selected are reasonable." (C.A. App. 37). That legal opinion was ignored. A subsequent warning from the Director of the Medicare Bureau to the HCFA Administrator that "[w]e are already on notice that the Office of General Counsel considers the guidelines that we recently issued on payment limits for CT scans legally unsupportable" also fell on deaf ears. (C.A. App. 110).

4. *Judicial proceedings below.* Having no avenue of relief available except resort to the courts, petitioners

brought this action in November 1979, in the United States District Court for the District of South Carolina. Petitioners asserted that the caps were established in violation of the rulemaking requirements of the APA. (C.A. App. 17). Petitioners also raised constitutional due process and equal protection challenges, attacking the procedure by which the caps were enforced and implemented and their arbitrary and discriminatory nature. (C.A. App. 16-17). Petitioners further contended that the procedure by which Part B determinations are made under the caps is contrary to the Medicare statute and regulations. (C.A. App. 9-10).

Petitioners sought injunctive relief from further implementation of the caps and an order directing that determinations as to Part B reimbursement for CT head scan services be made by Part B carriers without regard to the Secretary's caps. (C.A. App. 20-21).

Finding that the Secretary's establishment of the caps violated APA rulemaking requirements, the district court entered an order on March 6, 1980, granting petitioners' request for a preliminary injunction. The district court enjoined further implementation of the caps "until such time, if any, as the Secretary may lawfully promulgate regulations authorizing HEW [the predecessor to HHS] to set specific reimbursement caps for CT head scan services." (App. E, *infra*, App. 33). Jurisdiction was founded upon 28 U.S.C. § 1331 with respect to the APA rulemaking challenge.[2] A decision as to the merits of the

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[2]Having found jurisdiction to exist under 28 U.S.C. § 1331, the district court did not address the availability of mandamus jurisdiction under 28 U.S.C. § 1361.

other challenges presented by petitioners was reserved for trial.

Notwithstanding the representations of her counsel to the district court in December 1979, that appropriate regulations were being drafted for promulgation, the Secretary has never promulgated regulations authorizing the caps.

An interlocutory appeal, to which this matter relates, was brought by the Secretary to the Fourth Circuit in response to a subsequent order entered by the district court on April 16, 1982, denying the Secretary's motion to dismiss for lack of subject matter jurisdiction. The district court reaffirmed its finding of federal question jurisdiction over the APA rulemaking claim and added that judicial review would be appropriate for other challenges brought by petitioners to the establishment of the caps. (App. G, *infra*, App. 37-45).

On interlocutory appeal to the Fourth Circuit of the jurisdictional issue, the Secretary contended that 42 U.S.C. § 1395ii, which incorporates § 405(h) into the Medicare provisions of the Social Security Act, and 42 U.S.C. § 1395ff are absolute bars to judicial review of any conduct of the Secretary having any direct or indirect impact on the administration of Medicare Part B, even if the action arises under the rulemaking provisions of the APA, on constitutional grounds, or is otherwise collateral to benefit determinations.

The Fourth Circuit in its initial consideration of the jurisdictional issues disagreed with the Secretary and affirmed the district court's exercise of jurisdiction over the APA rulemaking claim under 28 U.S.C. § 1331. Fur-

ther, the court of appeals concluded that petitioners' constitutional and other statutory challenges to the Secretary's actions were subject to federal question jurisdiction. *Starnes v. Schweiker*, 715 F.2d 134 (4th Cir. 1983).

Even if federal question jurisdiction were unavailable, the Fourth Circuit in its initial decision further held that mandamus jurisdiction lies to decide the petitioners' challenges to the Secretary's actions. The court of appeals observed that mandamus is appropriate when there is (a) a clear right on the part of the plaintiffs to the relief sought, (b) a clear duty on the part of the defendants to do the act in question, and (c) no other adequate remedy available. Significantly, the court of appeals concluded that these conditions may all be met in the circumstances of this case, the third condition being met if federal question jurisdiction is not available. The court of appeals found that the third condition was also met in this case because the petitioners have exhausted all administrative remedies available to them, as well as some informal extrajudicial ones. 715 F.2d at 142.

Subsequently, on June 4, 1984, this Court granted the Secretary's petition for a writ of certiorari and, in the same order granting the writ, vacated the Fourth Circuit's initial judgment and remanded the case to the Fourth Circuit for further consideration in light of this Court's decision in *Ringer*. (App. C, *infra*, App. 6). In a per curiam opinion dated November 13, 1984, the Fourth Circuit interpreted *Ringer* to preclude federal question or mandamus review of any controversy affecting Medicare Part B, including petitioners' APA rulemaking challenge and constitutional and statutory claims, reasoning as follows:

Ringer establishes that we misread *Erika*. *Ringer* decides that Starnes' contention that there were procedural irregularities in the promulgation of the caps are so inextricably intertwined with a claim for benefits that any judicial review is barred by 42 U.S.C. § 1395ff. *See Ringer*, 466 U.S. at — n.4, and —, 104 S.Ct. at 2018 n.4 and 2021. It follows that the district court lacked jurisdiction under 28 U.S.C. §§ 1331 and 1361, and that the district court must dismiss the action for lack of subject matter jurisdiction. *Starnes v. Schweiker*, 748 F.2d 217, 218 (1984).

Petitioners submit that the court of appeals misread *Ringer* and that its decision on remand conflicts with a vast body of case law developed in other courts of appeals and with applicable decisions of this Court.

REASONS FOR GRANTING THE PETITION

I. The Decision of the Court of Appeals Denying Jurisdiction Under 28 U.S.C. § 1331 Conflicts With Decisions of Other Courts of Appeals and Applicable Decisions of This Court.

Petitioners challenge the unlawful conduct of the Secretary in establishing a reimbursement mechanism for determining allowable benefits under Medicare Part B for CT head scans, *i.e.*, the imposition of arbitrary caps, without subjecting such action to the APA rulemaking process.

The district court has preliminarily determined that the Secretary violated the notice and comment requirements of the APA in establishing the caps. HCFA's chief counsel concluded that such actions were violative of APA rulemaking requirements. Carriers throughout the nation opposed the Secretary's actions as being illegal and un-

reasonable. The district court and the court of appeals have determined that petitioners have exhausted their administrative remedies. Thus, if the Secretary's position in this case is upheld and judicial review of the petitioners' claims is denied, the Secretary will be left with unbridled discretion to pursue a clearly arbitrary and illegal course. Moreover, a far reaching precedent would be established that any procedural dispute that has even the most tangential effect on Part B reimbursement amounts would be precluded from judicial review. That would effectively exempt the entire Medicare Part B area from the provisions of the APA. As shown below, that is certainly not what Congress envisioned or other courts have held.

A. Other Courts Have Consistently Upheld Jurisdiction in Similar Circumstances Notwithstanding the Bars to Judicial Review in 42 U.S.C. §§ 405(h) and 1395ff.

The district court's exercise of jurisdiction over petitioners' APA rulemaking challenge in the circumstances of this case is supported by an abundance of authority, notwithstanding 42 U.S.C. § 405(h). The District of Columbia Circuit and other courts have consistently held that APA rulemaking challenges by Medicare claimants to actions by the Secretary without notice and opportunity to comment are subject to judicial review under 28 U.S.C. § 1331. *E.g., National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1,205 (1983); *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1,070 (D.C. Cir. 1978); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473 (9th Cir. 1981). As observed by those courts, a rulemaking challenge of the type brought by petitioners, who have re-

quested no monetary benefits, seeks to vindicate an interest in procedural regularity, rather than to recover on a claim arising under the Medicare statute as barred by 42 U.S.C. § 405(h). The analysis of the issue presented in the District of Columbia Circuit's opinion in *National Ass'n of Home Health Agencies* is still followed by the courts in the District of Columbia even in light of this Court's decision in *Ringer*. *Bio-Medical Applications of Providence, Inc. v. Heckler*, 593 F. Supp. 1,233 (D.D.C. 1984) (neither *Ringer* nor *Erika* precludes judicial review of Part B claimant's APA rulemaking challenge; such challenge was not "inextricably intertwined" with an underlying request for additional benefits); *see also College of American Pathologists v. Heckler*, 734 F.2d 859 (D.C. Cir. 1984).

Similarly, there is no basis for asserting that *United States v. Erika, Inc.*, 456 U.S. 201 (1982), interprets 42 U.S.C. § 1395ff to preclude an APA rulemaking challenge to actions of the Secretary. Unlike the present case, *Erika* involved a direct challenge to the determination of a carrier-appointed hearing officer as to the amount of benefits awarded to a supplier of medical services. The plaintiff's action in *Erika* was filed in the Court of Claims, and jurisdiction was asserted under The Tucker Act, 28 U.S.C. § 1491. No APA procedural rulemaking challenge was brought.

Recognizing the limited scope of the plaintiff's substantive challenge to the carrier's benefit amount determination, this Court narrowly framed the issue in *Erika* as "whether the Court of Claims has jurisdiction to review determinations by private insurance carriers of the amount of benefits payment under Part B of the Medicare statute." 456 U.S. at 201. The Court's opinion focused

upon the statutory language of 42 U.S.C. § 1395ff and legislative history indicating Congressional intent not to authorize judicial review of Part B controversies as to the allowable "amount" of benefits. That discussion and the decision in *Erika* are inapplicable to petitioners' APA rulemaking challenge. Neither 42 U.S.C. § 1395ff nor its legislative history even hint that Congress intended to bar judicial review of APA rulemaking claims brought by Part B participants.[3]

Similarly, there is nothing in the text or legislative history of 42 U.S.C. §§ 405(h) and 1395ff to suggest that judicial review under 28 U.S.C. § 1331 of the other challenges brought by petitioners to the Secretary's actions in the administration of Part B with respect to CT scanning services is foreclosed. The Fourth Circuit's decision on remand to that effect conflicts with this Court's decision in *Schweiker v. McClure*, 456 U.S. 188 (1982).

In *McClure*, a case decided on the same day as *Erika*, this Court implicitly recognized that challenges to actions

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[3]According to the legislative history cited in *Erika*, Congress did not want to overload the courts with "quite minor matters." 456 U.S. at 209. Since no monetary relief is sought in this case, petitioners have not sought to prove the amount of benefits that should be allowed for CT head scans. However, the Medicare program itself conducted a survey of carriers in 1979 which suggests that benefits for CT head scans were reduced by more than $8 million in one year alone by the caps. (C.A. App. 118). Unlike individual, case-by-case determinations of carriers as to the allowable amount of benefits based on the facts of a single case, the establishment of regional and nationwide caps by the Secretary can have a major impact. Obviously, in precluding judicial review of challenges to carrier determinations as to the amount of benefits in order to avoid overloading the courts with trivial matters, Congress did not intend to preclude APA rulemaking challenges such as this to actions by the Secretary that could have a dramatic impact on the Medicare program and the public.

of the Medicare program under Part B that are collateral to a claim for benefits are reviewable by the courts. The Court considered the merits of an action challenging the constitutionality of the Part B review and hearing process in *McClure*. Although the plaintiffs failed to succeed on the merits, this Court's consideration of the merits of their claim and its failure to question subject matter jurisdiction to consider the merits implicitly affirmed the lower court's determination that the plaintiffs' constitutional claims were collateral to their substantive claims for Medicare benefits and were therefore reviewable under the authority of *Mathews v. Eldridge*, 424 U.S. 319 (1976). *See McClure v. Harris*, 503 F. Supp. 409 (N.D. Cal. 1980). Thus, *McClure* supports the exercise of jurisdiction over petitioners' claims in this case.

It is a well established principle that an agency bears a "heavy burden of overcoming the strong presumption that Congress did not mean to prohibit all judicial review of an agency decision." *Dunlop v. Bachowski*, 421 U.S. 560, 567 (1975). *Accord, Johnson v. Robinson*, 415 U.S. 361 (1974); *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967). If an administrative official clearly departs from statutory authority, the administrative action is subject to judicial review even though a jurisdictional withdrawal statute is otherwise applicable. *Breen v. Selective Service Board*, 396 U.S. 460 (1970); *Graham v. Caston*, 568 F.2d 1,092 (5th Cir. 1978).

The strong presumption against preclusion of all judicial review notwithstanding 42 U.S.C. § 405(h) has been recognized by this Court in a line of Title II cases beginning with *Weinberger v. Salfi*, 422 U.S. 749 (1975). In *Salfi* this Court observed that a statute construed ab-

solutely to preclude consideration of a constitutional issue "would have raised a serious constitutional question of the validity of the statute." 422 U.S. at 762. In *Salfi* and *Mathews v. Eldridge*, 424 U.S. 319 (1976), the merits of certain claims presented by Title II claimants were addressed by this Court notwithstanding the limitations it imposed on the availability of federal question jurisdiction to challenges under the Social Security Act, and courts have subsequently interpreted *Eldridge* to authorize judicial review of claims that are collateral to a claim for benefits. Further, in *Califano v. Sanders*, 430 U.S. 99, 109 (1977), the Court noted that judicial review was available to the plaintiffs in *Salfi* and *Eldridge* under the statutory scheme in question and that a absolute bar to judicial review of constitutional questions would presumably be unconstitutional. The Fourth Circuit's decision on remand in this case conflicts with the principles enunciated by this Court in the above cases since it absolutely precludes all judicial review of petitioners' challenges.

Further, the exercise of jurisdiction over challenges to the Secretary's conduct in the administration of the Medicare program and where no alternative remedy is available is supported by a substantial body of case law developed by the courts of appeals from almost every circuit which have addressed the scope of various statutory bars under the Social Security Act to judicial review. *E.g.*, (1) 42 U.S.C. § 405(h): *United States v. Aquavella*, 615 F.2d 12 (2d Cir. 1979); *Colonial Penn Insur. Co. v. Heckler*, 721 F.2d 431 (3d Cir. 1983); *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n*, 630 F.2d 1,131 (6th Cir. 1980); *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), *cert. denied sub.*

nom., Faith Hospital Ass'n v. Blue Cross Hospital Services, Inc., 429 U.S. 977 (1976); *Daniel Freeman Memorial Hospital v. Schweiker*, 656 F.2d 473 (9th Cir. 1981); *College of American Pathologists v. Heckler*, 734 F.2d 859 (D.C. Cir. 1984); *National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1,205 (1983); (2) 42 U.S.C. § 1320a-1: *Hollingsworth v. Harris*, 608 F.2d 1,026 (5th Cir. 1979); *Humana Hospital Corp., Inc. v. Blankenbaker*, 734 F.2d 328 (7th Cir. 1984); *First Federal Savings & Loan Ass'n v. Casari*, 667 F.2d 734 (8th Cir.), *cert. denied*, 458 U.S. 1,106 (1982); (3) 42 U.S.C. § 1395oo(g): *Saint Mary of Nazareth Hospital Center v. Department of Health & Human Services*, 698 F.2d 1,337 (7th Cir.), *cert. denied*, 459 U.S. 1,205 (1983); *Holy Cross Hospital-Mission Hills v. Heckler*, 749 F.2d 1,340 (9th Cir. 1984); *Memoria' Hospital v. Heckler*, 706 F.2d 1,130 (11th Cir. 1983). The Fourth Circuit's decision on remand conflicts with each of those decisions.

B. The Court of Appeals' Preclusion of All Judicial Review Is Not Supported by Ringer.

The court of appeals' extreme interpretation of *Ringer* on remand to preclude all judicial review of the challenges to the Secretary's actions brought by the Part B claimants in this case is unwarranted. No alternative remedy is available to the petitioners in this case, whereas judicial review was ultimately available to the plaintiffs in *Ringer* after they exhausted available administrative remedies.

In *Ringer*, individual Medicare claimants brought an action challenging the policy of the Secretary denying

coverage under the Medicare program for a surgical procedure known as bilateral carotid body resection ("BCBR"). Unlike the CT head scan services involved in this case, the Secretary had determined that the BCBR procedure is not a "reasonable and necessary" service for the diagnosis or treatment of an illness or injury and, therefore, that Medicare beneficiaries are not entitled to any benefits for the procedure. *See* 42 U.S.C. § 1395y(a)(1). Three of the plaintiffs had filed claims for BCBR services and had been denied reimbursement, while a fourth purportedly needed the service but had not secured treatment for which a claim could be filed.

Rather than exhaust administrative remedies available to them under Part A, the claimants in *Ringer* sought immediate judicial relief under the estoppel-type notion that the Secretary had a constitutional and statutory obligation to provide payment for BCBR surgery because Administrative Law Judges had consistently ordered payment when they had previously considered individual BCBR claims of others. The plaintiffs sought a declaration that the Secretary's refusal to find that BCBR is "reasonable and necessary" is unlawful, an injunction compelling the Secretary to instruct her Part A intermediaries to provide payment for BCBR claims, and an injunction barring the Secretary from forcing claimants to pursue individual administrative appeals.

In a majority opinion, this Court held that 42 U.S.C. § 405(h) barred federal question jurisdiction of the plaintiffs' claims in *Ringer*. At the heart of the majority's decision lies the concern, voiced repeatedly throughout the opinion, that the plaintiffs had failed to exhaust available administrative remedies through Administrative Law

Judge and Appeals Council review, which was a statutory prerequisite to judicial review of all their claims under 42 U.S.C. § 405(g).

The Court's focus upon the exhaustion issue in *Ringer* is reflected in the majority's characterization of the relief sought by the three plaintiffs who had submitted claims:

> The relief respondents request is that the Secretary change her policy so as to allow payment for BCBR surgery so that respondents simply will not have to resort to the administrative process. 466 U.S. at —, 104 S.Ct. at 2,021.

That focus is also evident in the majority's comments on the fourth plaintiff's position:

> If we allow claimants in Ringer's position to challenge in federal court the Secretary's determination, embodied in her rule, the [sic] BCBR surgery is not a covered service, we would be inviting them to bypass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question. 466 U.S. at —, 104 S.Ct. at 2,025.

It is apparently because the majority was so concerned about the exhaustion issue in *Ringer* that it concluded that the plaintiffs' APA rulemaking challenge and other claims were "inextricably intertwined" with their claim for benefits:

> We agree with the District Court, however, that those claims are "inextricably intertwined" with respondents' claims for benefits. Indeed the relief that respondents seek to redress their supposed "procedural" objections is the invalidation of the Secretary's current policy and a "substantive" declaration from her that the expenses of BCBR surgery are reimbursable under the Medicare Act. We conclude that *all aspects*

> of respondents' claim for benefits should be channeled *first* into the administrative process which Congress has provided for the determination of claims for benefits. We, *therefore*, disagree with the Court of Appeals' separation of the particular claims here into "substantive" and "procedural" elements. 466 U.S. at —, 104 S.Ct. at 2,021 (emphasis added).

The above language of *Ringer* in no way suggests that all APA rulemaking claims, and other claims challenging the administrative conduct of the Medicare program, are always "inextricably intertwined" with claims for benefits and thereby barred by 42 U.S.C. § 405(h). When, as here, all administrative remedies have been exhausted, or when the plaintiffs are not seeking a "substantive" declaration that their claims are reimbursable, but rather ask only that the availability and amount of reimbursement be left to the discretion of carriers, the above language cannot fairly be read to lead to the extreme result reached by the Fourth Circuit on remand.

The above language of the Court in *Ringer* recognized that the plaintiffs' APA rulemaking challenge and other claims could ultimately be subjected to judicial review under the Part A review procedure prescribed by statute. No such result is possible here since no Part A claims are involved. *Ringer* does nothing to suggest that section 405(h) is a bar to federal question jurisdiction in Part B cases such as this in which there is no statutory review process culminating in judicial review.

Further, while the plaintiffs' APA and constitutional claims in *Ringer* may not have been collateral to their claims for benefits and, thereby, were found to "arise under" the Medicare Act within the meaning of section 405(h), that is because the majority found that the decla-

ration sought by the plaintiffs would surely result in the coverage they sought with essentially nothing left to administrative discretion:

> Following the declaration which respondents seek from the Secretary—that BCBR surgery is a covered service—only essentially *ministerial* details will remain before respondents would receive reimbursement. — U.S. at —, 104 S.Ct. at 2,022 (emphasis added).

Plainly, that reasoning is inapplicable here. The removal of caps on reimbursement for covered CT head scans until such caps are authorized by lawfully promulgated regulations, as sought by the petitioners here, merely results in the functioning of the administrative process as intended by Congress, *i.e.*, with carriers making reasonable charge determinations in their discretion under statutory guidelines and regulations promulgated by the Secretary.

While *Ringer* primarily addresses the Part A review process, the Fourth Circuit on remand interpreted the majority's decision in *Ringer* to expand the Supreme Court's prior decision in *Erika* concerning Part B by holding that judicial review of all challenges brought by Part B participants, and not just benefit amount determinations, are barred by 42 U.S.C. § 1395ff. The court of appeals also misinterpreted *Ringer* on that point.

The majority in *Ringer* relegated any mention of the plaintiffs' Part B claims to a single footnote. 466 U.S. at — n.4, 104 S.Ct. at 2,018 n.4. The Part B claims brought by the plaintiffs in *Ringer*, whatever may have been their nature, received scant attention by the Supreme Court and apparently by the parties. The Court noted that the plaintiffs had not pursued Part B claims in their brief, and neither party addressed any Part B aspects of the case in

oral argument. Thus, the court of appeals' translation of such a footnote in *Ringer* into a preclusion of all judicial review in the circumstances of this case is unsupported.

The most recent appellate decision to undertake a full analysis of *Erika* and the extent of section 1395ff's preclusion of judicial review of Part B claims is the District of Columbia Circuit's opinion in *College of American Pathologists v. Heckler*, 734 F.2d 859 (D.C. Cir. 1984), evaluating a challenge to regulations affecting Part B reimbursement for pathology services. Contrary to the Fourth Circuit's decision on remand, the District of Columbia Circuit in *College of American Pathologists* recognized the well established presumption that judicial review is available absent a clear congressional intent to the contrary and concluded that the legislative history of section 1395ff only reveals an intent to preclude review of Part B amount determinations. 734 F.2d at 862-63. A contrary analysis cannot be discerned from the majority's footnote in *Ringer*.

II. The Decision of the Court of Appeals Denying Mandamus Jurisdiction Under 28 U.S.C. § 1361 Conflicts With the Decisions of Other Courts of Appeals and Involves an Issue Yet To Be Resolved By This Court.

Plainly, the Fourth Circuit's interpretation of *Ringer* to preclude mandamus jurisdiction over petitioners' APA rulemaking challenge and other claims, in the face of its conclusion that all elements of an appropriate mandamus action are present if federal question jurisdiction is unavailable, is incorrect and in conflict with the decisions of other courts of appeals that have addressed the issue and have held that 42 U.S.C. § 405(h) does not bar judicial review under 28 U.S.C. § 1361.

While not deciding the issue, this Court in *Ringer* observed that mandamus jurisdiction under 28 U.S.C. § 1361 may be available in Social Security cases, notwithstanding 42 U.S.C. § 405(h), if the necessary elements of a mandamus action are present. 466 U.S. at —, 104 S.Ct. at 2,022. That was the consensus opinion of the courts of appeals that had addressed the issue prior to the Fourth Circuit's decision on remand in this case. *E.g., Dietsch v. Schweiker*, 700 F.2d 865 (2d Cir. 1983); *Ellis v. Blum*, 643 F.2d 68 (2d Cir. 1981); *Kuehner v. Schweiker*, 717 F.2d 813 (3d Cir. 1983); *Belles v. Schweiker*, 720 F.2d 509 (8th Cir. 1983); *Lopez v. Heckler*, 725 F.2d 1,489 (9th Cir. 1984); *Elliott v. Weinberger*, 564 F.2d 1,219 (9th Cir. 1977), *aff'd in part sub nom., Califano v. Yamaski*, 442 U.S. 682 (1979); *Martinez v. Richardson*, 472 F.2d 1,121 (10th Cir. 1973); *Ganem v. Heckler*, 746 F.2d 844 (D.C. Cir. 1984). The Fourth Circuit's decision on remand in this case is in direct conflict with that impressive array of appellate decisions.

As the Court observed in *Ringer*, a writ of mandamus is appropriate only if a plaintiff has exhausted all other avenues of relief and the defendant owes him a clear non-discretionary duty. 466 U.S. at —, 104 S.Ct. at 2,023. Those conditions are clearly satisfied here.

Both the district court and the court of appeals in its initial opinion have held that petitioners have exhausted all other avenues of relief, assuming that federal question jurisdiction is unavailable, and the Fourth Circuit did not reverse itself on that point in its decision on remand. Further, the district court has preliminarily determined that the Secretary violated a non-discretionary duty to petitioners to comply with the rulemaking requirements

of the APA, and the Fourth Circuit has not disagreed with that determination on the merits. The validity of petitioners' challenges to the actions of the Secretary are bolstered by the opinion of HCFA's chief counsel that the caps were not adopted in accordance with APA rulemaking requirements and the observations by carriers throughout the nation that the caps are illegal. The challenges brought by petitioners to the Secretary's actions, other than the APA rulemaking challenge, have yet to be considered by the district court.

In stark contrast, the majority in *Ringer* found each of the necessary elements for an appropriate mandamus action to be missing under the circumstances there:

> Here respondents clearly have an adequate remedy in § 405(g) for challenging all aspects of the Secretary's denial of their claims for payment for the BCBR surgery, including any objections they have to the instructions or to the ruling if either ultimately should play a part in the Secretary's denial of their claims. The Secretary's decision is to whether a particular medical service is "reasonable and necessary" and the means by which she implements her decision, whether by promulgating a generally applicable rule or by allowing individual adjudication, are clearly discretionary decisions. See 42 U.S.C. § 1395ff(a); see also *Heckler v. Campbell*, 461 U.S. 458, 103 S.Ct. 1952, 1957, 76 L.Ed.2d 66 (1983). 466 U.S. at —, 104 S.Ct. at 2,023.

The *Ringer* majority's conclusion that it is a matter of discretion as to the means by which the Secretary implements a decision as to whether a particular service is "reasonable and necessary," *i.e.*, whether by promulgating a generally applicable rule or by allowing individual adjudication, in no way suggests that the claims brought by

the petitioners in this case challenge discretionary actions on the part of the Secretary. The decision by the Secretary to implement her decision as to the allowable charge for CT head scans by promulgating a generally applicable rule or by allowing individual adjudication by carriers may be a discretionary decision. Once the Secretary decides, however, to implement such a decision by a statement of general policy subject to rulemaking requirements of the APA, she has a clear, non-discretionary duty to abide by the APA notice and comment procedures, but that did not occur here.

Ringer implicitly recognizes that compliance with APA rulemaking requirements is a non-discretionary duty in its reliance upon *Heckler v. Campbell*, 461 U.S. 458 (1983). While *Campbell* supports the notion that the Secretary has the discretion to rely on regulations of general applicability rather than individualized determinations, that is because the Supreme Court in that case assumed that rulemaking procedures leading to "valid" regulations were undertaken, and it observed that "the rulemaking proceeding itself provides sufficient procedural protection." 461 U.S. at 470. *See also Smith v. Schweiker*, 709 F.2d 777 (2d Cir. 1983) ("[m]andamus jurisdiction does not lie where the claims are not against the Secretary for failure to comply but rather are directed at the propriety of the regulations themselves"). No such procedural protection has been afforded to the petitioners in this case, and no regulations authorizing the caps in question have been promulgated. Petitioners' challenge to the Secretary's failure to comply with APA rulemaking requirements involves a non-discretionary duty.

———o———

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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February 1985

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1543

Eula B. Starnes, Johnnie Kaye Lloyd, Nettie E. Clarkson, Jayne E. Dunlap, individually and on behalf of others similarly situated; Julian Adams, M.D., Fred H. Allen, Jr., M.D., William H. Stuart, M.D., Rhett O. Talbert, M.D., Atlanta Neurological Clinic, P.C., C. T. Scanlab and Trident Neuroimaging Laboratory, individually and on behalf of others similarly situated,

Appellees,

vs.

Richard S. Schweiker, Secretary of Health and Human Services,

Appellant,

and

Prudential Insurance Company of America and Blue Cross and Blue Shield of South Carolina, Inc., individually and on behalf of others similarly situated,

Defendants.

On Remand from the Supreme Court of the United States.

Submitted: July 10, 1984 Decided: November 13, 1984

Before WINTER, Chief Judge, PHILLIPS, Circuit Judge, and MERHIGE, United States District Judge for the Eastern District of Virginia, sitting by designation.

Leslie L. Clune, Dept. of Health & Human Services (J. Paul McGrath, Assistant Attorney General, Henry Dargan McMaster, United States Attorney, Juan A. del Real, General Counsel, Lynne K. Zusman, Deputy General Counsel, Litigation on brief) for Appellants; John H. Parker, Jr. (J. Marbury Rainer, Parker, Hudson & Rainer; Alexander M. Sanders, Jr., Sanders & Quackenbush on brief) for Appellees.

PER CURIAM:

The Supreme Court of the United States vacated our judgment in Starnes v. Schweiker, 715 F.2d 134 (4 Cir. 1983) and remanded the case for further consideration in light of Heckler v. Ringer, 466 U.S. — (1984). *See* Heckler v. Starnes, — U.S. — (June 4, 1984). We conclude that in the light of *Ringer* the judgment of the district court must be reversed.

In the instant case the district court preliminarily enjoined the Secretary of Health and Human Services from implementing nationwide or regional caps on reimbursement under Part B of the Medicare Program for computerized tomography ("CT") scans until the Secretary had complied with the Administrative Procedure Act. It ruled that it had jurisdiction to grant such relief and that plaintiffs had made a prima facie showing that the caps were promulgated in violation of the rulemaking requirements of the Administrative Procedure Act. It reserved its judgment on the substantive and constitutional challenges to the validity of the caps.

In review of the jurisdictional question, we concluded that the district court had jurisdiction either under 28 U.S.C. § 1331 or under the mandamus statute, 28 U.S.C. § 1361. We recognized that United States v. Erika, 456 U.S. 201 (1982), held that judicial review of Part B benefit amount determinations was barred by 42 U.S.C. § 1395ff, but we did not read *Erika* to construe § 1395ff to bar judicial review of the Secretary's administration of the Part B program, as distinguished from the correctness of benefit determinations thereunder.

Ringer establishes that we misread *Erika*. *Ringer* decides that Starnes' contention that there were procedural irregularities in the promulgation of the caps are so inextricably intertwined with a claim for benefits that any judicial review is barred by 42 U.S.C. § 1395ff. *See Ringer*, — U.S. at — n.4, and —. It follows that that the district court lacked jurisdiction under 28 U.S.C. §§ 1331 and 1361, and that the district court must dismiss the action for lack of subject matter jurisdiction.

REVERSED.

APPENDIX B

JUDGMENT

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1543

Eula B. Starnes, Johnnie Kaye Lloyd, Nettie E. Clarkson, Jayne E. Dunlap, individually and on behalf of other similarly situated; Julian Adams, M.D., Fred H. Allen, Jr., M.D., William H. Stuart, M.D., Rhett O. Talbert, M.D., Atlanta Neurological Clinic, P.C., C.T. Scanlab and Trident Neuroimaging Laboratory, individually and on behalf of others similarly situated,

Appellees,

vs.

Richard S. Schweiker, Secretary of Health and Human Services,

Appellant,

and

Prudential Insurance Company of America and Blue Cross and Blue Shield of South Carolina, Inc., individually and on behalf of others similarly situated,

Defendants.

Appeal from the United States District Court for the District of South Carolina.

Pursuant to remand of the Supreme Court of the United States, this cause came on to be heard on the record from the United States District Court for the District of South Carolina, and argument previously submitted by counsel.

On consideration whereof, It is now here ordered and adjudged by this Court that the judgment of the said District Court appealed from, in this cause, be, and the same is hereby, reversed.

Filed November 13, 1984

U S Court of Appeals Fourth Circuit

/s/ John M. Greacen,
Clerk

APPENDIX C

SUPREME COURT OF THE UNITED STATES

June 4, 1984

Margaret M. Heckler, Secretary of Health and Human Services, et al.,

v.

Eula B. Starnes, et al.

No. 83-1149

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

The petition for a writ of certiorari is granted. The judgment is vacated and the case is remanded to the United States Court of Appeals for the Fourth Circuit for further consideration in light of Heckler v. Ringer, 466 U.S. — (1984). Justice White took no part in the consideration or decision of this case.

APPENDIX D

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT

No. 82-1543

Eula B. Starnes, Johnnie Kaye Lloyd, Nettie E. Clarkson, Jayne E. Dunlap, individually and on behalf of others similarly situated; Julian Adams, M.D., Fred H. Allen, Jr., M.D., William H. Stuart, M.D., Rhett O. Talbert, M.D., Atlanta Neurological Clinic, P.C., C.T. Scanlab and Trident Neuroimaging Laboratory, individually and on behalf of others similarly situated,

Appellees,

vs.

Richard S. Schweiker, Secretary of Health and Human Services,

Appellant,

and

Prudential Insurance Company of America and Blue Cross and Blue Shield of South Carolina, Inc., individually and on behalf of others similarly situated,

Defendants.

Argued Feb. 10, 1983
Decided Aug. 16, 1983

Before WINTER, Chief Judge, PHILLIPS, Circuit Judge, and MERHIGE,* District Judge.

HARRISON L. WINTER, Chief Judge:

We granted leave to take this interlocutory appeal to settle the question of whether the district court had

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*Hon. Robert R. Merhige, Jr., United States District Judge for the Eastern District of Virginia, sitting by designation.

jurisdiction to decide procedural, substantive and constitutional challenges to benefit levels set by the Secretary of Health and Human Services to guide private insurance carrier benefit determinations under Part B of the Medicare statute. The district court ruled that it had jurisdiction. It exercised its jurisdiction, however, only to grant a preliminary injunction based upon a prima facie showing of a procedural deficiency in the manner in which the Secretary proceeded, reserving judgment on the substantive and constitutional challenges.

We conclude that the district court has jurisdiction either under 28 U.S.C. § 1331 or, under the mandamus statute, 28 U.S.C. § 1361. Accordingly, we affirm the judgment of the district court.

I.

Part B of the Medicare Program is a voluntary medical insurance program for the aged and disabled, funded by monthly premiums and contributions from general revenues of the federal government. Part B supplements the general coverage of Part A by insuring against some medical expenses not covered by the latter. Determinations of benefits paid for Part B coverage are made by private insurance carriers employed by the Secretary in accordance with regulations and policy guidelines issued by the Secretary. Persons to whom Part B is applicable are entitled to reimbursement of 80 percent of the "reasonable charge" for covered medical services, including physicians' services. 42 U.S.C. § 1395k. Under the Medicare Act, the Secretary's determinations as to eligibility for benefits under Parts A and B are administratively reviewable, as are his determinations of benefits under

Part A if the amount in controversy exceeds $100, with a right of judicial review. 42 U.S.C. § 1395ff. No determination of the amount of benefits under Part B is administratively or judicially reviewable. Once a carrier determines benefits owed to a claimant, they are actually paid out of a government trust fund.

Plaintiffs are (a) Medicare beneficiaries enrolled in Part B of the Medicare Program, and (b) physicians and clinics which provide computerized tomography ("CT") scans to the class of Medicare patients which the Medicare beneficiary plaintiffs represent. Plaintiffs brought this class action to challenge the establishment and implementation by the Secretary of nationwide and regional ceilings or caps on Part B reimbursements for CT head scans. Through several letters or memoranda the Secretary has established a national ceiling on reimbursement for such services. In June 1977, the Regional IV Office (Atlanta) sent letters to all Part B carriers in Region IV proposing that no more than $150 be paid for CT head scans. In December 1977 a memorandum was issued to all Regional Medicare Directors indicating that $150 was a reasonable charge for CT scans. In September 1978 the nationwide caps were adjusted by a letter issued to all insurance carriers which indicated that a reasonable charge for CT scans should range from $157.50 to $172.50, with the amount allowed in a particular case to depend upon whether contrast enhancement was used in the scan.

The named plaintiffs unsuccessfully exhausted their administrative remedies before bringing this action to challenge the directives. They appealed benefit determinations to carrier-appointed hearing officers, the only administrative remedy provided under the Act, 42 U.S.C.

§ 1395u(b)(3) (C), and they have informally petitioned the Secretary and the Regional Offices for relief from the caps. The Secretary and his subordinates have been steadfast in enforcing the caps, although the Secretary's counsel advised that the Secretary should proceed in accordance with the Administrative Procedure Act and "make a case in the rulemaking record" why the caps selected are reasonable.

Plaintiffs challenge the cap on a number of grounds. They contend that the Secretary's informal letters, directives and memoranda establishing the caps constitute rulemaking without notice and opportunity for comment, in violation of the Administrative Procedure Act, 5 U.S.C. § 553(b). They contend that the caps violated their equal protection and due process rights by depriving them of property rights without notice or opportunity for comment and by arbitrarily and unreasonably imposing a different standard for the determination of CT scan benefits than is used for the determination of other Part B benefits. They contend that the caps are inconsistent with the Medicare Act's requirements that carriers, and not the Agency, determine the reasonableness of charges on which benefits to be paid to claimants are computed. And, they assert that the caps violate the requirement that the customary and prevailing charge be paid for Part B services. They seek an injunction against enforcement and implementation of the caps and a direction to the Secretary that she withdraw the caps, advise all Part B carriers of their withdrawal and require all carriers who have applied the caps to recompute claims and make additional payments with interest where indicated. As sup-

plemental relief plaintiffs request costs and attorneys' fees.

On March 6, 1980, the district court ruled that it had jurisdiction over all of plaintiffs' claims, concluded the caps were promulgated in violation of the APA's rule-making requirements and preliminarily enjoined their implementation nationwide until regulations authorizing such caps were properly promulgated. The district court reaffirmed its jurisdictional holding on April 16, 1982, reserving ruling on plaintiffs' other contentions, and certified the question for appeal to this court. We granted leave to maintain it.

II.

Plaintiffs allege jurisdiction in the district court by virtue of 28 U.S.C. § 1331 (federal question jurisdiction), § 1346 (suits against the United States involving federal questions), and § 1361 (mandamus jurisdiction). They also allege jurisdiction under 5 U.S.C. §§ 701-706, the Administrative Procedure Act, but it is well-settled that that Act contains no independent grant of jurisdiction. *See Califano v. Sanders*, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977). Thus we consider, first, if there is federal question jurisdiction, and, second, if there is jurisdiction to grant a writ of mandamus. The Secretary argues that federal court jurisdiction is barred by two provisions of the Medicare Act, 42 U.S.C. § 1395ff and 42 U.S.C. § 1395ii. We discuss them seriatim.

A. 42 U.S.C. § 1395ff

As we have previously described, § 1395ff provides that the Secretary shall determine eligibility for the Part

A and Part B programs and benefit amounts for the Part A program, and that judicial review of these determinations may be had pursuant to 42 U.S.C. § 405(g). It does not, however, empower the Secretary to determine benefit amounts under the Part B program, nor does it provide for judicial review of carrier determinations.[1] In-

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[1]Section 1395ff provides:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in sec-

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stead, Part B benefit determinations are made by private insurance carriers and are appealable only to carrier-appointed hearing officers. 42 U.S.C. § 1395u.

In two recent cases, the Supreme Court has addressed this scheme. In *United States v. Erika*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), it held that § 1395ff forbade judicial review of Part B benefit amount determinations made by carriers. And, in *Schweiker v. McClure*, 456 U.S. 188, 102 S.Ct. 1665, 72 L.Ed.2d 1 (1982), it found no due process violation in the use of carrier-appointed hearing officers to resolve disputes over benefit amounts and in the denial of a right to de novo administrative review of their determinations.

We find nothing in the language of § 1395ff nor in the Supreme Court's opinion in *Erika* to suggest that the Secretary's administration of the Part B program, as distinguished from the correctness of benefit determinations thereunder, should not be subject to judicial oversight. The language of § 1395ff indicates that Congress sought to preserve judicial review of actions taken by the Secretary, but not actions taken by private carriers. Section 1395ff renders reviewable those actions to be performed by the Secretary—Part A benefit amount determinations and Part A and Part B eligibility determinations—while those actions which are delegated to private carriers—Part B benefit amount determinations—are made

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tion 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

unreviewable. In the discussion of the section in the Act's legislative history, only benefit amount determinations are said to be unreviewable, and in each instance it is also noted that private carriers, and not the Secretary, are responsible for those determinations.[2]

Erika held that particular carrier benefit determinations are unappealable. The Court phrased the question presented there as whether there is "jurisdiction to review determinations by private insurance carriers of the amount of benefits payable under Part B of the Medicare statute." 456 U.S. at 205-208, 102 S.Ct. at 1653-1654, 72 L.Ed.2d at 17-18. And it agreed with the position that the United States had taken in the case that "Congress, by enacting the Medicare statute . . . specifically precluded review in the Court of Claims of adverse hearing officer determinations of the amount of Part B payments." 456 U.S. at 206-207, 102 S.Ct. at 1653-1654, 72 L.Ed.2d at 17-18. Moreover, *McClure* suggests that some degree of

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[2]The Senate Report stated: "Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A." S.Rep. No. 404, 89th Cong. 1st Sess., [1965] U.S.Code Cong. & Admin. News 1943, 1975. When § 1395ff(b) was amended in 1972, Congress re-emphasized the absence of judicial review on Part B determinations, again noting the Secretary was not responsible for these decisions. The House Report on the amendments stated: "There is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B . . ." H.R. Rep. No. 92-1605, 92d Cong.2d Sess. 61 (1972), U.S.Code Cong. & Admin.News 1972, pp. 5370, 5394. From this, we discern that Congress unmistakably intended that carrier determinations be unreviewable.

judicial oversight of the Part B program is preserved, despite § 1395ff, for the Supreme Court assumed without discussion that it possessed jurisdiction to hear a constitutional challenge to the benefit determination procedures provided by Congress.

Erika does, however, compel the conclusion that a plaintiff cannot seek to reopen a benefit determination by challenging a regulation or some other action by the Secretary which influenced it. The suit in *Erika* was brought by a distributor of kidney dialysis supplies to challenge the implementation by an insurance carrier of a regulation defining the reasonable charge for a service on the basis of its price in the year prior to the year in which the service was rendered. The Court of Claims concluded that the regulation was invalid, and directed the carrier to recalculate benefits owed to the plaintiff by some more accurate method. *Erika, Inc. v. United States*, 634 F.2d 580, 589 (Ct.Cl. 1980). In finding the Court of Claims to be without jurisdiction, then, the Supreme Court implicitly held that a carrier benefit determination could not be reopened even though it was alleged to be unlawful because of some action by the Secretary.

McClure, however, strongly suggests that a benefit determination may be reviewed and reopened when the alleged infirmity is constitutional in nature. In that case the Supreme Court both assumed that it possessed jurisdiction over a due process challenge to the procedures followed in prior determinations and left open the door to future constitutional challenges to benefit determinations when it could be proven that the carrier-appointed hearing officer was biased. 456 U.S. at 195-198, 102 S.Ct. at 1670-1671, 72 L.Ed.2d at 8-9. The issue was not ad-

dressed in *Erika,* for while a constitutional claim had been made below it was held to be insubstantial and was not pressed before the Supreme Court. 456 U.S. at 206 n. 5, 102 S.Ct. at 1653 n. 5, 72 L.Ed.2d at 17 n. 5.

Prior to *Erika* there was universal agreement that actions by the Secretary and even private carriers could be assailed on constitutional grounds in either a district court, *Kechijian v. Califano,* 621 F.2d 1 (1 Cir. 1980); *Pushkin v. Califano,* 600 F.2d 486 (5 Cir. 1979); *Cervoni v. Secretary of Health, Ed. & Welfare,* 581 F.2d 1010 (1 Cir. 1978); *St. Louis Univ. v. Blue Cross Hosp. Serv.,* 537 F.2d 283 (8 Cir.) *cert. den. sub nom. Faith Hospital Assoc. v. Blue Cross Hosp. Serv., Inc.,* 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584 (1976), or the Court of Claims, *Bussey v. Harris,* 611 F.2d 1001 (5 Cir. 1980); *Drennan v. Harris,* 606 F.2d 846 (9 Cir. 1979). We see no reason to depart from this position for there is no indication in the Act's legislative history that Congress intended a result so drastic as, by the enactment of § 1395ff, to preclude judicial enforcement of the Constitution with respect to the administration of the Part B Program of Medicare. Thus to immunize the Secretary and the carriers from the Constitution's mandate would raise a constitutional question of the gravest sort, and we decline to adopt such an interpretation unless that is clearly the will of Congress. *See Weinberger v. Salfi,* 422 U.S. 749, 762, 95 S.Ct. 2457, 2465, 45 L.Ed.2d 522 (1975); *Johnson v. Robison,* 415 U.S. 361, 366-367, 373, 94 S.Ct. 1160, 1165-1166, 1168, 39 L.Ed.2d 389 (1974).

In sum, we hold § 1395ff does not restrict whatever right the plaintiffs may have to seek prospective relief from the Secretary's actions, but that it does bar the re-

opening of past benefit determinations on other than constitutional grounds.

B. 42 U.S.C. § 1395ii

Federal question jurisdiction would undoubtedly exist but for the possible bar of 42 U.S.C. § 1395ii which incorporates 42 U.S.C. § 405(h) into the Medicare Act. Specifically, § 1395ii states that "(t)he provisions . . . of subsection . . . (h) . . . of Section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter." Section 405(h), thus made applicable, states:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

The precise meaning and scope of § 405(h) has been the subject of a large and ever-expanding body of case-law. *Weinberger v. Salfi,* 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), is the first and most significant authority. There the Supreme Court held that a constitutional challenge to a duration of relationship requirement of the Social Security Act was a claim "arising under" the Act, which § 405(h) removed from federal question jurisdiction under 28 U.S.C. §§ 1331 and 1346. In reach-

ing this result, the Court interpreted § 405(h) literally, to bar use of § 1331 as a jurisdictional basis for any claim arising under the Social Security Act. *Id.* at 757, 95 S.Ct. at 2462. It found that the challenge to the Act's duration of relationship eligibility requirement did arise under the Act since the plaintiffs ultimately sought to recover Social Security benefits and the Act provided them with "both the standing and the substantive basis for the presentation of their constitutional claims." *Id.* at 760-761, 95 S.Ct. at 2464-2465. Perhaps significantly, the Act did provide another mechanism for raising the question, and the Court ruled that jurisdiction existed to review the individual plaintiff's claim under 405(g). *Id.* at 763-767, 95 S.Ct. at 2465-2467.

Since *Salfi* the Supreme Court has had occasion to discuss § 405(h) in several other cases. Generally, the Court has held it to bar use of § 1331 as a jurisdictional basis for Social Security Act claims while expanding the possibilities for judicial review and relief under § 405(g). Thus, in *Mathews v. Eldridge,* 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976), the Court held that a due process challenge to disability benefit termination procedures was a claim "arising under" the Act which could only be presented under § 405(g). But, it sustained jurisdiction over Eldridge's claim by interpreting the exhaustion requirement of that section to be waivable so long as a claim for benefits was submitted to the Secretary. In *Norton v. Mathews,* 427 U.S. 524, 96 S.Ct. 2771, 49 L.Ed.2d 672 (1976), it deemed a constitutional challenge brought by an illegitimate child to a certain dependency provisions to be so insubstantial that it could be rejected on the merits without deciding whether there was jurisdiction over

the case. In *Califano v. Sanders, supra,* it held the APA was not an independent jurisdictional basis for claims arising under the Social Security Act. In *Califano v. Yamasaki,* 442 U.S. 682, 689, 99 S.Ct. 2545, 2551, 61 L.Ed.2d 176 (1979), it held that class actions and nationwide injunctive relief were permissible under § 405(g). In *Schweiker v. McClure,* 456 U.S. 188, 102 S.Ct. 1665, 72 L.Ed.2d 1 (1982), the Court assumed, without discussion, that it possessed jurisdiction over a constitutional challenge to benefit determination procedures. Finally, in *United States v. Erika,* 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982), it held that § 1395ff of the Act barred appeals of Part B benefit determinations, and did not consider § 405(h).

Plaintiffs argue that these precedents do not foreclose their contention that § 1331 jurisdiction exists to redress the Secretary's violation of APA, and we agree. There is persuasive authority for that proposition and we conclude to follow it.[3] *See, e.g., National Association*

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[3]Both in *Mathews v. Eldridge,* 424 U.S. 319, 327, 96 S.Ct. 893, 899, 47 L.Ed.2d 18 (1976) and *Califano v. Sanders,* 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977), it was assumed that a due process challenge to benefit termination procedures, and a challenge to the Secretary's refusal to reopen a disability determination, respectively, were barred by § 405(h). We cannot read either case as a square holding to that effect, especially since the claimant in *Mathews* had sought a reinstatement of benefits as an inseparable part of his procedural claim. *See Humana,* 590 F.2d at 1080-81 n. 76. We also note *Hopewell Nursing Home, Inc. v. Schweiker,* 666 F.2d 34, 39 (4 Cir. 1981). There we held that a claim fell within the scope of § 405(h), even though the requested relief was an order that benefits be recomputed and not necessarily increased, since the plaintiff's ultimate objective, in fact, was to increase its benefits. In that case the plaintiff had made several procedural claims in the district court, but they were not pressed on appeal and we did not rule on them.

of Home Health Agencies v. Schweiker, 690 F.2d 932 (D.C. Cir. 1982); *Daniel Freeman Memorial Hosp. v. Schweiker,* 656 F.2d 473 (9 Cir. 1981); *Humana of South Carolina, Inc. v. Califano,* 590 F.2d 1070, 1080 (D.C. Cir. 1978); *St. Louis Univ. v. Blue Cross Hosp. Serv.,* 537 F.2d 283, 291-294 (8 Cir.); *cert. den. sub nom. Faith Hosp. Ass'n v. Blue Cross Hosp. Serv. Inc.,* 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584 (1976). *But see Hadley Memorial Hosp., Inc. v. Schweiker,* 689 F.2d 905, 910-12 (10 Cir. 1982). These cases limit the bar of § 405(h) to claims brought to recover benefits and permit the exercise of § 1331 jurisdiction to adjudicate any other right for which no alternative form of judicial relief is available.

The *Home Health Agencies* case is one of the most persuasive in this line of authorities. It is also one of the latest and it collects all of the pertinent authorities extant at the time it was decided. There, numerous home health agencies and a trade association attacked the validity of regulations requiring home health agencies to seek medicare reimbursement determinations and payment from government-designated regional intermediaries. Because there was no statutory right of judicial review, they sought to invoke federal question jurisdiction to adjudicate their claims that the Secretary had illegally violated the Medicare Act, the APA and denied them due process in promulgating the regulation. As to the jurisdictional issue, the court of appeals held that, in the absence of a statutory right of judicial review, the district court had federal question jurisdiction to decide the issue on their merits, and, moreover, the lack of a statutory right of judicial review did not evidence congressional intent to deny federal question jurisdiction. It stressed that there

was not legislative history to indicate that, by the enactment of § 405(h), Congress intended to preclude federal question jurisdiction other than in those instances when an alternative statutory right of judicial review had been established, and that the exercise of federal question jurisdiction was not counter to the purpose of § 405(h). Finally it ruled that the fact that Congress had provided for a statutory right of review in other instances did not overcome the general presumption in favor of judicial review.

As we view plaintiffs' complaint, the gravamen of their action with respect to the alleged violation of APA, the alleged violation of the Medicare Act and the alleged violation of their constitutional rights,[4] is to redress those violations. Of course a well-founded complaint in that regard has a secondary effect on the benefits and payments due them. It may well be true that the effect of the preliminary injunction suspending enforcement of the caps granted by the district court entitles plaintiffs to be paid more than they would receive were the caps being enforced. But we do not perceive the suit essentially one to recover benefits; it is a suit to enforce lawful conduct on the part of the Secretary. *Cf. Ringer v. Schweiker,* 684 F.2d 643, 646 (9 Cir. 1982). We hold therefore that federal question jurisdiction existed in the district court.

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[4]The allegation that there is a constitutional right to notice and opportunity to comment when an agency makes rules of general applicability is frivolous. It presents no substantial procedural constitutional claim. *See, e.g., Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc.,* 435 U.S. 519, 542 n. 16, 98 S.Ct. 1197, 1211 n. 16, 55 L.Ed. 2d 460 (1978).

III.

We recognize that, in deciding that federal question jurisdiction exists to litigate plaintiffs' procedural challenge, we decide a close case. It may well be that a higher reviewing court may be of the opinion that we have misconstrued §§ 1395ff or 405(h) or the authorities which have considered them. But if there is not federal question jurisdiction to decide plaintiffs' challenges, then we think that there is mandamus jurisdiction under 28 U.S.C. § 1361 to do so.

The federal mandamus statute, added by the Mandamus and Venue Act of 1962, provides an independent grant of jurisdiction to compel an officer or employee of the United States to perform a duty owed to the plaintiff. *See* 28 U.S.C. § 1361. As collected in *Ellis v. Blum*, 643 F.2d 68, 78-82 (2 Cir. 1981), there is an impressive array of cases holding that § 1361 provides a jurisdictional basis to review procedures employed in administering social security benefits.[5] Three, *Ellis v. Blum, supra, White v. Mathews*, 559 F.2d 852, 856 (2 Cir. 1977), *cert. denied*, 435 U.S. 908, 98 S.Ct. 1458, 55 L.Ed.2d 500 (1978); and *Barnett v. Califano*, 580 F.2d 28 (2 Cir. 1978), have held that § 405(h) does not preclude mandamus jurisdiction to review the Secretary's procedures in disability cases. They

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[5]The Supreme Court has left open the question whether § 405(h) prohibits reliance on § 1361 as a jurisdictional basis for cases arising under the Social Security Act. *Califano v. Yamasaki*, 442 U.S. at 697-698, 99 S.Ct. at 2555-2556; *Norton v. Mathews*, 427 U.S. at 529-530, 96 S.Ct. at 2774-2775. *Mathews v. Eldrige*, 424 U.S. at 332 n. 12, 96 S.Ct. at 901 n. 12. *But see Califano v. Sanders*, 430 U.S. at 111, 97 S.Ct. at 987 (Burger, C.J., and Stewart, J., concurring) (§ 405(h) limits jurisdiction to claims properly brought under § 405(g)).

reason that § 1361 does not come within the literal scope of § 405(h) either as it currently stands—it refers only to sections 1331 and 1346—or as it was originally enacted —it then forbade utilization of all jurisdictional provisions contained in section 41 of Title 28, but mandamus jurisdiction at that time was vested solely in the District of Columbia by virtue of the Act of February 27, 1802, 2 Stat. 103. Moreover, they note that preserving mandamus jurisdiction is not contrary to the purpose of § 405(h), which is to prevent circumvention of the jurisdictional provisions provided by the Medicare Act, since it will only lie if no other remedy is available to the plaintiff.

We think that these holdings are applicable here. We held in *Burnett v. Tolson*, 474 F.2d 877 (4 Cir. 1973), that mandamus will lie when there is (a) a clear right on the part of the plaintiffs to the relief sought, (b) a clear duty on the part of the defendant to do the act in question, and (c) no other adequate remedy available. These conditions may all be met here, the third being met if we are incorrect in our conclusion that jurisdiction under § 1331 lies, notwithstanding § 405(h). Certainly the third condition is also met because plaintiffs have exhausted all administrative remedies available to them as well as having unsuccessfully pursued some informal extra-judicial ones.[6]

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[6]This conclusion does not conflict with our earlier decision in *Hopewell Nursing Home, Inc. v. Schweiker*, 666 F.2d 34 (4th Cir. 1981). In that case, we held that mandamus jurisdiction did not lie because the second condition was not met; it was "difficult to imagine how the Secretary could have failed to perform a duty owed the providers—*i.e.*, granting them a final decision on their claims—when they have not given him an opportunity to do so by availing themselves of the administra-

(Continued on next page)

Even if jurisdiction rests solely on § 1361, we think that the grant of interim injunctive relief was proper. Mandamus jurisdiction under § 1361 permits flexible remedies, including injunctive or declaratory relief. *Crawford v. Cushman,* 531 F.2d 1114, 1126 (2 Cir. 1976); *Burnett v. Tolson, supra,* 474 F.2d at 883. Although the question is relatively novel, we see no reason why a preliminary injunction should not also be available in an appropriate case, and in one case reported, preliminary relief was awarded on the basis of mandamus jurisdiction. *See Dull Knife v. Morton,* 394 F.Supp. 1299 (D.S.D. 1975). That the preliminary injunction may have the effect of increasing benefit payments for CT head scans until the caps are properly promulgated is no objection to its issuance. A court acting under mandamus jurisdiction may compel the payment of benefits by the government. *See, e.g., White v. Mathews, supra; Nat'l Treasury Employees Union v. Nixon,* 492 F.2d 587 (D.C. Cir. 1974). We express no view, however, as to whether the district court may also compel the retroactive payment of increased benefits. That issue is not yet before us because the district court only barred the implementation of the caps prospectively. *Cf. Nat'l Treasury Employees Union v. Nixon, supra* (retroactive pay increase may be ordered); *De Lao v. Califano,* 560 F.2d 1384 (9 Cir. 1977) (doctrine of sovereign immunity bars retroactive order).

AFFIRMED.

(Continued from previous page)

tive process." *Id.* at 42. We thus indicated that mandamus jurisdiction was unavailable to those plaintiffs who failed to exhaust administrative remedies, absent a showing that the Secretary frustrated exhaustion by failing to act on the plaintiff's administrative claims. The named plaintiffs here, however, have exhausted their administrative remedies.

APPENDIX E

IN THE DISTRICT COURT
OF THE UNITED STATES FOR THE
DISTRICT OF SOUTH CAROLINA

COLUMBIA DIVISION

Civil Action No. 79-2311-6

Eula B. Starnes, et al., Plaintiffs

—versus—

Patricia R. Harris, Secretary of Health,
Education and Welfare, et al., Defendants

ORDER

This matter came on to be heard upon plaintiffs' verified Complaint and Application for a Temporary Restraining Order. Instead of issuing a Temporary Restraining Order on an *ex parte* basis, the court held a hearing on December 11, 1979, to consider a Preliminary Injunction against defendant's alleged improper implementation of ceilings ("caps") on reimbursement for computerized tomography head scans (hereinafter "CT head scans") under Part B of the Medicare Program. The plaintiffs are Medicare beneficiaries and physicians and physician-directed clinics which provide CT head scan services to Part B beneficiaries. Class action certification has not yet been granted to the purported plaintiff classes or to the purported defendant class. The plaintiffs challenge the alleged reimbursement caps on various substantive and procedural grounds, including the contention that the Secretary of Health, Education and Welfare (hereinafter "HEW") has imposed reimbursement caps with-

out complying with the requirements of the Administrative Procedure Act (hereinafter "APA"), 5 U.S.C. §§ 551-59 and 701-06.

"There can be no disputing the Secretary's statutory authority to define by regulation the method of computing 'reasonable cost' for charges for which a provider . . . seeks reimbursement under the Medicare program, nor the power of Congress to clothe the Secretary with the power to exercise that authority." *Fairfax Hospital Ass'n. v. Califano,* 585 F.2d 602, 605-06 (4th Cir. 1978). Even so, it is equally clear that such authority must be properly exercised.[1]

During the December hearing, the court became concerned that, as conceded by HEW, the alleged reimbursement caps had not been formulated in accordance with APA requirements despite an opinion from HEW's Office of General Counsel that, in order to properly establish such caps, HEW "will have to (1) proceed by rulemaking rather than by intermediary letter and (2) make a case in the rulemaking record for why the caps selected are reasonable." Complaint, Exhibit D, Letter from Galen Powers, HEW Assistant General Counsel to Robert Derzon, Administrator of HEW Health Care Financing and Human Development Services Division (Aug. 16, 1978). In support of its conclusion, the opinion letter cited the "substantial impact" test developed by some courts in assessing the necessity for following rulemaking procedure.

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[1]While HEW's rulemaking activity on benefits questions was exempt from Administrative Procedure Act requirements before 1971, during that year the Secretary waived the exemption and submitted to the Act's provisions. 36 Fed.Reg. 2532 (1971).

See Pickus v. United States Board of Parole, 507 F.2d 1107 (D.C. Cir. 1974). It went on to analogize the instant issues to those considered in *Schupak v. Mathews*, MEDICARE AND MEDICAID GUIDE (CCH) ¶ 27,987 (D.D.C. Sept. 17, 1976), in which an ESRD formula which controlled reimbursements paid to dialysis facilities was held invalid because it had not been imposed pursuant to proper rulemaking procedure under the APA. The opinion letter noted that although the invalidation order in *Schupak* had been stayed until HEW had an opportunity to promulgate a formula by regulation, other courts have invalidated HEW regulations on procedural grounds without granting such stays. *See National Welfare Rights Organization v. Mathews*, 533 F.2d 637 (D.C. Cir. 1976); *Maryland v. Mathews*, 415 F.Supp. 1206 (D.D.C. 1976). Finally, the opinion letter suggested that "there is a very good possibility (especially considering that the Department received fair warning in the *Schupak* case) that a court would not stay its invalidation of an intermediary letter that purported to establish [caps on reimbursement] for CT scans."

In its Memorandum opposing injunctive relief, HEW contends that its Intermediary Letter 78-38 (Complaint, Exhibit C) is not inconsistent with its own counsel's opinion letter because it does not impose a cap on CT scan reimbursement, but only "provides direction and guidance to carriers as to how they should proceed when applying the reasonable charge methodology to develop screens for new and costly medical services and diagnostic procedures, such as CT scans." This quotation, taken from the Intermediary Letter itself, is followed by HEW's additional statement that "in this intermediary letter . . .

we have provided our own conclusions as to appropriate reasonable charge limitations for these services."

While HEW attempts to distinguish the two, this court concludes that the intent and effect of Intermediary Letter 78-38 is substantially the same as that of a more explicit and less artfully worded cap on reimbursement. Indeed, while on page 9 of its Memorandum HEW makes the above-mentioned denial that any cap was imposed, on page 10 of the same Memorandum, HEW complains that plaintiffs "bring this action more than two years *after imposition of the cap* . . . ." (emphasis added).

Despite its serious reservations about the procedural validity of HEW's action, the court withheld entry of a preliminary injunction, because defendants' counsel at the December hearing indicated that HEW was in the process of developing proposed regulations which would authorize HEW to set specific reimbursement caps for a variety of medical services, including CT head scans, and that HEW expected to submit those proposals to proper APA rulemaking process in the near future. Based upon these representations, the court directed HEW's counsel to submit a clarification of the scope of the proposed regulations and the anticipated time schedule for rulemaking.

On December 18, 1979, HEW submitted its Report, which set out a target date of October, 1980, for publication of a final regulation. The Report gave no assurance that publication would be achieved even by October 1980. Instead, it conditioned the proposed schedule upon internal approvals of drafts of the proposed regulations. Contrary to the court's impression from the December hearing, it appears that the proposed regulation has not already been through the draft and approval process.

The court afforded the parties an opportunity to request a second hearing prior to its ruling, but no party sought an additional hearing.

Therefore, from the submissions of record, the December hearing and the applicable law, the court concludes as follows:

1. That this court has subject matter jurisdiction in this action under 28 U.S.C. § 1331 and the reasoning enunciated in *Hopewell Nursing Home, Inc. v. Califano*, MEDICARE AND MEDICAID GUIDE (CCH) ¶ 28,718 (D.S.C. Dec. 20, 1977). This court cleaves to its previous conclusion that *Weinberger v. Salfi*, 422 U.S. 749 (1975), and 42 U.S.C. § 405(h), do not preclude judicial review where the claims presented are not otherwise reviewable. *See Whitecliff, Inc. v. United States*, 536 F.2d 347, (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977).

2. There are no administrative remedies to be exhausted in the plaintiffs' procedural challenge to the promulgation of the CT reimbursement caps.

The court expresses no opinion at this time on the separate issue of exhaustion of administrative remedies by the plaintiffs under the substantive (*i.e.*, non-procedural) challenges asserted in the Complaint. *See Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978) (recognizing that exhaustion requirements may differ, depending, *inter alia*, upon the procedural or substantive nature of the challenge and that substantive challenges to the amount of cost reimbursement due to a provider for accounting periods ending on or after June 30, 1973, require exhaustion of administrative remedies by

submission to the Provider Reimbursement Review Board before institution of suit in federal district court).

3. That defendant Harris, her predecessor as Secretary of HEW, their agents, representatives, and employees have, since December, 1977, established, authorized, and approved the implementation of a nationwide cap on reasonable charge reimbursement under Part B of the Medicare program for CT head scanning services and, since July 1, 1977, prior to the implementation of the nationwide ceiling, have established, authorized, and approved the implementation of a similar cap in Region IV of the Medicare Bureau.

4. That defendants Prudential Insurance Company of America, Blue Cross and Blue Shield of South Carolina, Inc., and other local "carriers" for Part B of the Medicare program have, acting in concert with defendant Harris, her predecessor in office, their agents, representatives, and employees, implemented the Region IV and nationwide reimbursement cap.

5. That the Region IV and nationwide reimbursement cap are lower than the customary and prevailing charges of physicians and physician-directed clinics for CT head scans.

6. That the authorization, direction, and implementation of said cap on Medicare reimbursement for CT head scanning services appear to be illegal and unauthorized in that such actions, having been taken without notice and opportunity to comment upon them and without a statement of their basis and purpose based upon such comments by interested persons, constitute improper rulemaking in violation of the Administrative Procedure Act.

7. That defendant Harris and her subordinates, the defendant carriers, and other members of the purported class of carriers under Part B will continue to implement the nationwide cap unless restrained by Order of this court.

8. That immediate and irreparable harm, injury, and damage will result to plaintiffs and to the public before a trial can be conducted on plaintiffs' prayer for a permanent injunction in that

(a) many members of the purported class of Medicare beneficiaries who desire and need CT head scan services but cannot afford to obtain such services from a physician or physician-directed clinic whose services are subject to the cap will be forced to seek such services, if at all, from hospitals not subject to the nationwide cap, even though the nearest hospital possessing a CT scanner may be less accessible and less convenient to said individuals and they may not receive the same quality of care. As a result, said Medicare beneficiaries will be deprived of the freedom of choice guaranteed to them by Congress to secure quality medical services from any qualified physician or institution of their choosing;

(b) members of the purported class of physicians and physician-directed clinics will be discouraged, contrary to the policy of the Medicare law, from accepting assignments from potential Medicare patients. As a result, their reputations will be damaged among their Medicare patients and within their communities, and many potential Medicare patients will be forced to seek CT head scan services, if at all, from competing hospitals possessing CT scanners. Said physicians and physician-directed clinics

will suffer monetary losses, the amount of which may not be capable of exact determination; and

(c) the cost of the Medicare program to the public may be increased substantially because Medicare beneficiaries who have sought CT head scan services from physicians or physician-directed clinics having CT scanner facilities but for the nationwide cap, will secure such services from hospitals which possess CT scanners. The additional cost to the public for providing CT services to a Medicare beneficiary in a hospital setting, rather than in a physician-directed office or clinic, may be substantial.

9. That greater injury will be inflicted upon plaintiffs and other members of the purported class of Medicare beneficiaries and the purported class of physicians and physician-directed clinics adversely affected by the nationwide cap by the denial of the relief requested by plaintiffs than will result to defendant Harris, the defendant carriers, and other members of the purported class of carriers under Part B by the granting of said relief.

10. That the public interest will be served by the granting of the relief requested by plaintiffs.

IT IS THEREFORE ORDERED that defendant Harris, her agents, representatives, and employees, and other acting in concert with them including defendant carriers and other members of the purported class constituted by all carriers under Part B of the Medicare program, be and they hereby are enjoined from authorizing, directing, recommending, acquiescing in, approving, and implementing any caps under Part B on CT head scan reimbursement which are inconsistent and in conflict with the criteria which were applied by carriers in making rea-

sonable charge determinations for CT head scan services before ceilings were established by the Medicare program.

This preliminary injunction shall continue until such time, if any, as the Secretary may lawfully promulgate regulations authorizing HEW to set specific reimbursement caps for CT head scan services or untl further Order of this court.

It is further ORDERED that plaintiffs shall give security in the sum of $5,000.00 for the payment of such costs and damages as may be incurred or suffered by any party, or parties, who may be found to have been wrongfully enjoined or restrained.

AND IT IS SO ORDERED.

/s/ Charles E. Simons, Jr.
Charles E. Simons, Jr.
United States District Judge

Columbia, S.C.
March 4th, 1980.

APPENDIX F

IN THE DISTRICT COURT
OF THE UNITED STATES
FOR THE DISTRICT OF SOUTH CAROLINA

COLUMBIA DIVISION

Civil Action No. 79-2311-6

Eula B. Starnes, et al., Plaintiffs

—versus—

Richard S. Schweiker, Secretary of Health and Human Services, et al., Defendants

This matter comes before the court upon the Motion of defendant Blue Cross and Blue Shield of South Carolina, Inc. ("BCBS"), for Summary Judgment or for an Order dropping the defendant BCBS as a party defendant. In the alternative, BCBS has moved for an Order severing the claim against it from the claims asserted against other defendants. Subsequently, the defendant Secretary of Health and Human Services (the "Secretary") moved the court to dismiss Prudential Insurance Company of America and BCBS as defendants in this action.

Plaintiffs have opposed these motions on the grounds that, under the circumstances of this case, the Part B Medicare carriers are proper parties defendant whose presence is necessary to insure full and adequate relief and that an independent claim has been asserted against BCBS and other similarly situated Medicare carriers.

Having considered the written motions of defendants and responses of plaintiffs and the arguments made by counsel for both sides in a hearing before this court, the

Motion of BCBS for Summary Judgment or for an Order dropping BCBS, or, in the alternative, for an Order severing the claim asserted against BCBS is denied. The Secretary's Motion to Dismiss is also denied.

Also before the court is plaintiffs' Motion for a determination under Fed. R. Civ. P. 23 that this case be maintained as a class action. Defendants have opposed the Motion, arguing that a class action would serve no useful purpose in this case. Having considered the briefs of the parties, the record to date in this action, and the oral arguments of the parties, the court concludes that the prerequisites for maintaining a class action set out in Fed. R. Civ. P. 23(a) are met in this case, and that this action may be maintained as a class action under Fed. R. Civ. P. 23(b) (2). Therefore, plaintiff's Motion for determination of class action is hereby granted, and this action shall henceforth be maintained as a class action on behalf of the following classes:

(1) A Medicare beneficiaries' class consisting of all past, present and future Medicare beneficiaries enrolled in the Supplementary and Medical Insurance Benefits for the Aged and Disabled Program (42 U.S.C. §§ 1395j-1395w), commonly known as Part B of Medicare Program, who have sought or desire to secure Medicare reimbursement for CT head scan services during such period that Medicare reimbursement for CT services may have been and/or may be subject to the alleged arbitrary ceilings more fully described in the Complaint in this action; and

(2) A physicians' class consisting of all physicians and physician-directed clinics which now (or in the future) own, operate and use CT scanners in rendering head

scan services to Medicare patients enrolled under Part B of the Medicare Program during such period that Medicare reimbursement for CT services may have been and/or may be subject to the alleged arbitrary ceilings more fully described in the Complaint in this action.

AND IT IS SO ORDERED.

/s/ Charles E. Simons, Jr.
Charles E. Simons, Jr.
United States District Judge

Aiken, S.C.
October 19, 1981

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

COLUMBIA DIVISION

Civil Action No. 79-2311-6

Eula B. Starnes, et al., Plaintiffs

vs.

Richard S. Schweiker, Secretary of Health and Human Services, et al., Defendants

ORDER

Plaintiffs, Medicare beneficiaries enrolled in Part B of the Medicare Program ("Part B") and physicians and physician-directed clinics which own, operate and use computerized tomography ("CT") scanners in rendering CT head scan services to Medicare patients, brought this suit as a class action to challenge the establishment and implementation by defendants of certain alleged regional and nationwide ceilings or "caps" on Part B reimbursement for CT head scans (hereinafter the "caps").* Defendants, the Secretary of Health and Human Services ("HHS") and certain private insurance carriers under contract with the Secretary, are responsible for supervising and conducting the administration of Part B.

Part B is a voluntary insurance program which provides medical insurance benefits for aged and disabled

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*The Medicare program is governed by 42 U.S.C. § 1395 *et seq.* (Title XVIII of the Social Security Act, as amended) (hereinafter the "Medicare Act").

individuals who elect to enroll in the program. 42 U.S.C. § 1395j. It is financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government. Subject to certain deductibles and coinsurance requirements, a Part B beneficiary is generally entitled to have payments made to him, or on his behalf to an assignee, for the reasonable charge for physicians' and other medical services covered by the program.

Plaintiffs challenge the caps on various procedural, substantive, and constitutional grounds. Plaintiffs contend that the caps were established in violation of the procedural rulemaking requirements of the Administrative Procedure Act ("APA") (5 U.S.C. §§ 552-53). Plaintiffs further contend that the caps are substantially invalid in that they are lower than the actual, customary, and prevailing charge criteria for reasonable charge determinations under Part B (42 U.S.C. § 1395u(b) (3)); they preclude Part B carriers from performing their duties under the governing statute and regulations (42 U.S.C. § 1395u(a)(1)(A); 42 C.F.R. §§ 405.501, 405.502 (c)); and they violate fundamental tenets of Medicare law pertaining to the delivery of, and access to, health services (42 U.S.C. §§ 1395, 1395a). Finally, plaintiffs assert that the caps violate their constitutional guarantees of equal protection and due process.

On March 6, 1980, this Court entered an Order enjoining defendants from implementing the caps "until such time, if any, as the Secretary may lawfully promulgate regulations authorizing HEW [now HHS] to set specific reimbursement caps for CT head scan services" on the

ground that the caps were not established and implemented in accordance with the procedural rulemaking requirements of the APA. The Court determined that its subject matter jurisdiction was founded upon 28 U.S.C. § 1331 and the reasoning enunciated in *Hopewell Nursing Home, Inc. v. Califano,* CCH Medicare and Medicaid Guide, ¶ 28,718 (D.S.C., December 20, 1977), and that *Weinberger v. Salfi,* 422 U.S. 749 (1975) and 42 U.S.C. § 405(h), did not preclude judicial review where the claims presented were not otherwise reviewable. No decision was reached concerning plaintiffs' substantive and constitutional claims.

No regulations authorizing the caps have been promulgated by the Secretary, and the March 6, 1980 Order remains in effect. Plaintiffs' motion for summary judgment seeking a permanent injunction against future implementation of the caps and an order requiring reimbursement adjustments where the caps were inconsistent with the reasonable charge methodology previously in effect is pending.

On October 20, 1981, this Court determined that this action may be maintained as a class action under Fed.R. Civ.P. 23(b)(2) and certified two nationwide plaintiff classes: (1) all past, present, and future Medicare beneficiaries enrolled in Part B who have sought or desire to secure Medicare reimbursement for CT head scan services during such period that Medicare reimbursement for CT services may have been and/or may be subject to the caps; and (2) all physicians and physician-directed clinics which now (or in the future) own, operate, and use CT head scanners in rendering head scan services to part B Medicare beneficiaries during the same period. The Court also declined to dismiss the defendant carriers as parties.

This matter is now before the Court on defendants' Motion to Dismiss for Lack of Jurisdiction prompted by the recent decision of the Court of Appeals for the Fourth Circuit, which reversed the jurisdictional holding of the District Court in *Hopewell, supra. Hopewell Nursing Home, Inc. v. Schweiker,* 666 F.2d 34 (4th Cir. 1981). It is the defendants' position that Congress expressly precluded judicial review of Part B reimbursement disputes such as this one by incorporating into the Medicare Act the provisions of 42 U.S.C. § 405(h). See 42 U.S.C. § 1395ii. Section 405(h) provides, in part, as follows:

> No finding of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 41 of Title 28 to recover on any claim arising under this subchapter.

The Medicare statute provides for judicial review of certain beneficiary claims (i.e., the determination of whether an individual is entitled to benefits under Part A or Part B of the Medicare program, and the determination of the amount of benefits under Part A.) 42 U.S.C. § 1395ff. Defendants argue that because there is no statutory provision for obtaining judicial review of Part B benefit determinations, § 405(h) precludes such review and deprives this court of subject matter jurisdiction over this action. The legislative history of these Medicare provisions is cited extensively by defendants to support their contention that Congress intended to preclude entirely judicial review of claims respecting the amount of benefits payable under Part B. Moreover, defendants contend that

all of plaintiff's claims arise under the Medicare statute and that judicial review of the entire action is barred. *Weinberger v. Salfi*, 422 U.S. 749 (1975).

This court rejected defendants' jurisdiction arguments when it issued its March 6, 1980 Order, and concluded that 42 U.S.C. § 405(h) does "not preclude judicial review where the claims presented are not otherwise reviewable." Since that conclusion was premised in part on reasoning articulated in the district court's opinion in *Hopewell Nursing Home, Inc. v. Califano, supra*, and since the Court of Appeals for the Fourth Circuit reversed the *Hopewell* court's decision, defendants argue again that the instant action should be dismissed.

Hopewell was brought as a class action by nursing homes that participated as providers in the Medicare program and their owner-administrators to challenge certain intermediary surveys used to compile ranges of compensation paid to administrators in the region, which were in turn used by the intermediaries in making reasonable cost determinations for reimbursement purposes.* The *Hopewell* plaintiffs challenged the survey and the use of the ranges of compensation as being in violation of Medicare law and regulations; contrary to the Secretary's own instructions; arbitrary and capricious, unconstitutional, contrary to the rulemaking requirements of the APA, and in violation of the Federal Records Act.

The district court held in *Hopewell* that it had subject matter jurisdiction under 28 U.S.C. § 1331 (general

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*Fiscal intermediaries are the Medicare Part A counterparts of Part B carriers. Providers such as hospitals and nursing homes, are generally reimbursed for their reasonable costs under Part A.

federal question jurisdiction) and that the surveys were flawed and violated the Medicare law and regulations. It ordered defendants to recalculate reimbursement payable to plaintiffs in 1971 and each year thereafter. The Court of Appeals reversed, holding that by operation of § 405(h), subject matter jurisdiction under 28 U.S.C. § 1331 was precluded and that plaintiffs' failure to comply with the statutory jurisdictional prerequisites of 42 U.S.C. § 1395oo, which provides for appeal to the Provider Reimbursement Review Board (PRRB) and subsequent judicial review, deprived the district court of jurisdiction under the Medicare statute. The court also found that mandamus jurisdiction was unavailable.

The Court of Appeals remanded the *Hopewell* case to the district court with instructions to dismiss those of plaintiffs' claims that arose after 1973, when the statute's Part A jurisdictional provisions became operative. With respect to pre-1973 claims for which the Medicare statute provided no avenue to federal court review, the Court of Appeals deferred judgment, holding that only after plaintiffs had satisfied the statute's jurisdictional prerequisites for post-1973 should the district court examine its authority over the pre-1973 portion of the case. In so doing, the court followed the decision of the District of Columbia Circuit in *Humana of South Carolina, Inc. v. Califano*, 590 F.2d 1070 (D.C. Cir. 1978).

It is plaintiffs' position that subject matter jurisdiction lies under 28 U.S.C. § 1331. First, plaintiffs contend that procedural rulemaking challenges under the APA are subject to judicial review notwithstanding 42 U.S.C. § 405(h) and *Salfi* since they arise under the APA, rather than the Medicare Act. Principal reliance in this regard is

placed upon the decision of the District of Columbia Circuit in the *Humana* case, *supra*, which distinguished procedural rulemaking callenges under the APA from substantive challenges to Medicare reimbursement determinations. 590 F.2d at 1080.

Next, plaintiffs argue that the reasoning of the Fourth Circuit in *Hopewell* supports subject matter jurisdiction over their substantive and constitutional challenges under 28 U.S.C. § 1331. In declining to dismiss the pre-PRRB Part A claims, the Fourth Circuit observed that the preclusion of all judicial review would be of "disputable constitutionality." *Hopewell Nursing Home, Inc.*, 666 F.2d at 41. By analogy to the Fourth Circuit's treatment of those pre-PRRB Part A claims, plaintiffs argue that it would be improper to dismiss their substantive and constitutional challenges since the Medicare Act does not establish administrative procedures culminating in judicial review under Part B.

Furthermore, plaintiffs attempt to distinguish the facts in *Hopewell* and this case with respect to the exhaustion issue. While the plaintiffs in *Hopewell* made no attempt to secure administrative review of their claims through Part A PRRB process, certain Medicare beneficiaries and physicians, including several named plaintiffs in this case, challenged the CT caps by appealing reimbursement determinations to carrier-appointed hearing officers, without success. The only avenue of appeal of Part B reimbursement disputes is an appeal of claims involving more than $100 to a Part B carrier-appointed hearing officer. 42 U.S.C. § 1395u(b)(3)(C). Plaintiffs argue that this Part B appeal mechanism is analogous to the pre-PRRB Part A appeal mechanism, which provided for appeal only to Part A intermediary hearing officers.

Plaintiffs also point out that they sought relief from the Secretary at a regional and then a national level prior to bringing this action, and they argue that the Office of General Counsel advised the Administrator of the Health Care Financing Administration that the caps were illegal under the APA in that they were not established through rulemaking and that Part B carriers had advised the Secretary that the caps were unreasonable and illegal. Accordingly, plaintiffs contend that there were no further administrative appeals to exhaust.

As an additional basis for jurisdiction, plaintiffs assert that mandamus jurisdiction lies against the Secretary under 28 U.S.C. § 1361. *Arkansas Soc'y of Pathologists v. Harris,* Medicare and Medicaid Guide (CCH) ¶ 30,706 (E.D. Ark., August 22, 1980); *Waitley v. Califano,* Medicare and Medicaid Guide (CCH) ¶ 39,141 (D. Kan. 1978); *see Burnett v. Tolson,* 474 F.2d 677 (4th Cir. 1973). In *Hopewell,* the Fourth Circuit denied mandamus jurisdiction, finding it particularly inappropriate in view of the absence of a showing by the plaintiffs that the Secretary would not act on claims presented to him. 666 F.2d at 42. Plaintiffs have attempted to distinguish *Hopewell,* citing their efforts to secure administrative relief from the CT caps, and assert that mandamus jurisdiction would lie under the facts of this case.

In its March 6, 1980 Order, this Court concluded that it had subject matter jurisdiction under 28 U.S.C. § 1331. Having examined *Hopewell,* this Court remains unconvinced that its earlier finding of jurisdiction was erroneous. The Court believes that plaintiffs' APA procedural rulemaking claim is not barred by 42 U.S.C. § 405(h). In view of the Fuorth Circuit's treatment and the pre-PRRB

claims in *Hopewell,* the Court does not believe that all judicial review of plaintiffs' substantive and constitutional challenges should be precluded. Therefore, defendants' Motion to Dismiss is DENIED.

The Court believes, however, that this order involves a controlling question of law as to which there is substantial ground for difference of opinion, *i.e.,* whether 42 U.S.C. § 405(h) precludes judicial review of plaintiffs' procedural and substantive claims.

The court is aware that two cases now pending before the Supreme Court may involve related questions, but that neither squarely presents the issue decided here. See *Erika, Inc. v. United States,* 647 F.2d 129 (Ct. Cl. 1981), *cert. granted,* No. 81-1594, — U.S. —, 101 S.Ct. 2312 (1981); *McClure v. Harris,* 503 F.Supp. 409 (N.D. Cal. 1981), *cert. granted,* No. 81-212, — U.S. —, 104 S.Ct. 2298 (1981). For these reasons, the Court is of the opinion that an immediate appeal from the order may materially advance the ultimate termination of the litigation, and therefore certifies this order for appeal in accordance with the provisions of 28 U.S.C. § 1292(b).

It is further ordered by this Court that action on plaintiffs' pending Motion for Summary Judgment and Defendants' Motion for Reconsideration of Class Determination be continued pending resolution of the jurisdictional question by the Fourth Circuit Court of Appeals.

/s/ Charles E. Simons, Jr.
Charles E. Simons, Jr.
Chief Judge, United States
District Court

Columbia, S.C.
April 15, 1982

APPENDIX H

STATUTORY PROVISIONS INVOLVED

1. 28 U.S.C. 1331 provides:

Federal question

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. 28 U.S.C. 1361 provides:

Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

3. 5 U.S.C. § 553 provides:

Rule Making

(a) This section applies, according to the provisions thereof, except to the extent that there is involved—

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally

served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except—

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

4. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

(h) Finality of Secretary's decision

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

5. Section 1869(a) and (b) of the Social Security Act, 42 U.S.C. 1395ff(a) and (b), provides:

Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the de-

termination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or subsection 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.